Events That Affect Your Benefits

Important Facts for Part-Time Local 587 Employees

This guide explains:

? How King County administers your benefit plans
? COBRA, family-medical leave and disability accommodation programs
? Your rights and responsibilities under the plans and programs.

The Resource Directory on the last two pages lists contact details for all the plans, programs and services referenced in the guide. More information is available in your benefit plan booklets and Regular Benefits, Flexible Spending Accounts and Exit Guides.

Though plan booklets and guides are regularly updated, some information may change between printings. For the most current materials, please go to www.metrokc.gov/ohrm/benefits or contact the resources listed in the directory.

King County Office of Human Resources Management
BENEFITS & WELL-BEING

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✝ Benefit Eligibility

You

If you're a part-time transit operator or an assigned or on-call employee represented by Local 587, you are eligible for one of three benefit plans -- Plan 1, Plan 2 or Plan 3.

You're also eligible for other county benefits, as explained in enrollment materials and the Flexible Spending Account (FSA) Guide. These include:

- Employee bus pass and other services available through the Employee Transportation Program
- Health and dependent care FSAs
- Deferred compensation
- Free and confidential personal counseling services through the Making Life Easier Program
- Home mortgage assistance
- Mildly sick child care.

You're not eligible for these benefits if you work less than half time or are a temporary or seasonal employee, or if you work in a capacity that, at the discretion of Human Resources, is considered contract labor or independent contracting. If you're not treated as a common law employee by King County for income tax withholding (regardless of any later determination of legal employment status), you're not benefit-eligible.

Plan 1. You become eligible the first of the month following your hire date (the day after you qualify) or the first of the month you're hired if your hire date is the first of the month.

Under Plan 1 you may purchase the following combinations of coverage:

- Medical only for you or you and your family members
- Medical and dental for you or you and your family members
- Medical and vision for you or you and your family members
- Medical, dental and vision for you or you and your family members
- Vision only for you or you and your family members
- Basic life insurance ($20,000) for you.

You may elect family coverage only if you elect coverage for yourself; dental coverage only if you elect medical coverage.

You pay for benefits through payroll deduction. Half the monthly cost is taken from each paycheck (when you receive three paychecks in a month no deductions are taken from the last one). You may have benefit payments deducted before or after your federal income and Social Security taxes are withheld.

- If you have payments deducted before taxes are withheld, taxes are reduced, but IRS regulations apply. You may not drop any coverage until the next open enrollment unless it's due to a qualifying change (for example, death of a family member, divorce or dissolution of a domestic partnership, change in the number of your dependents or a significant change in your spouse or domestic partner's employment status). Any portion of the plan premiums you pay to provide coverage to a domestic partner or domestic partner's children generally must be deducted after taxes. You must re-enroll each year during open enrollment to continue this payment option.
- If you have payments deducted after taxes are withheld, you may drop coverage for yourself or a family member at any time. This is the default payment plan if you do not choose one or do not re-enroll for the before-tax payment plan during open enrollment each year.

If you move among Plan 1, Plan 2 and Plan 3 during the calendar year, the benefit premium payment plan you choose for the calendar year remains in effect through the end of the year. You may change payment plans only during open enrollment.

Plan 2. You become eligible when you:

? Pick a work assignment of at least four hours per day for a shake-up or
? Receive at least 338 paid hours in a four-month qualifying period prior to the start of the shake-up (four-month qualifying periods are January-April, April-July and September-December).

Plan 2 benefits become effective for specific benefit-eligible periods beginning 45 to 60 days after the start of the shake-up. Benefit-eligible periods are:

? April 1-July 31 (four months) for the shake-up that usually begins in February
? August 1-October 31 (three months) for the shake-up that usually begins in May or June
? November 1-March 31 (five months) for the shake-up that usually begins in September.

Once you've enrolled, Plan 2 coverage extends for additional benefit-eligible periods as long as you continue to meet eligibility requirements.

Under Plan 2 you receive county-paid:

? Medical, dental and vision coverage for yourself and family members
? Basic life ($25,000), accidental death and dismemberment (AD&D/$25,000) and long term disability (LTD/180-day waiting period) insurance for yourself.

You may also purchase enhanced:

? Life for yourself ($25,000, $50,000, $75,000 or $100,000)
? Life for your family (spouse/domestic partner 50% of your enhanced amount, children $5,000)
? AD&D for yourself ($50,000 to $500,000, in $50,000 increments)
? AD&D for your family (spouse/domestic partner 50% or 100%, children 10% of your enhanced amount)
? LTD for yourself (reducing the basic 180-day waiting period to 90 days).

If you and your spouse/domestic partner are both county employees, you may cover only yourself for enhanced life and AD&D (you may not enroll each other for spouse/domestic partner coverage) and only one of you may cover your children for enhanced life and AD&D.

Plan 3. If you lose eligibility for Plan 2, you become eligible to self-pay to continue coverage under Plan 3. Under Plan 3 you receive the same county-paid basic life ($25,000), AD&D ($25,000) and long term disability insurance (180-day waiting period) you had under Plan 2, but must self-pay to continue:

? Medical, dental and vision coverage for yourself and family members
? Any of the enhanced life, AD&D or LTD you had under Plan 2.

You may drop coverage or you may drop family members from coverage, as long as the change results in a combination of coverage as described for Plan 1.

If you continue medical, you must continue with the same medical plan you had under Plan 2 and the same benefit premium payment plan you were enrolled in for the calendar year (if you self-paid for previous coverage) unless the Plan 2 to Plan 3 change occurs during open enrollment.

If the Plan 2 to Plan 3 change occurs during open enrollment, you may pick a different medical plan (it becomes effective November 1) and a different benefit premium payment plan (as described under Plan 1; it becomes effective January 1).

Family Members

The following family members are eligible under your coverage if you enroll them:

- Your spouse/domestic partner (copy of marriage certificate or an Affidavit of Marriage/Domestic Partnership must be filed with Benefits & Well-Being)
- Unmarried children of you or your spouse/domestic partner who are:
  - Under age 23 and chiefly dependent on you for support and maintenance (generally, that means you claim them on your federal tax return). A child may be your natural child, adopted child, stepchild, legally designated ward, child placed with you as legal guardian, child legally placed with you for adoption, or a child for whom you assume total or partial legal obligation for support in anticipation of adoption.
  - Named in a Qualified Medical Child Support Order (QMCSO) as defined under federal law and authorized by the plan (next page).
  - Incapacitated due to developmental or physical disability and chiefly dependent on you for support. The child must have become incapacitated while covered by the plans and before age 23. To continue an incapacitated child's coverage, you must submit a Request to Continue Benefit Coverage for Disabled Adult Child Form to Benefits & Well-Being within 60 days of the child's 23rd birthday. You must submit proof of the child's continued disability periodically thereafter. An incapacitated child is not eligible for life insurance.

Children younger than 14 days old are not eligible for life or AD&D coverage.

Domestic Partners Under Plan 2. There is no cost for family member health coverage under Plan 2. However, when you cover a domestic partner and domestic partner's children for health benefits (medical, dental, vision), the IRS taxes you on the value of the coverage. The value is added to the salary shown on your paycheck (and W-2 at the end of the year); federal income tax is withheld on the higher salary amount and then the value is subtracted from your salary.

Qualified Medical Child Support Order. In accordance with applicable law, the plans provide medical, dental and vision coverage to certain children of yours (called "alternate recipients") if directed by certain court or administrative orders. These include a decree, judgment or order from a state court (including approval of a settlement agreement) or an administrative order that requires these plans to include a child in your coverage and make any applicable payroll deductions.

A QMCSO is generally considered qualified and enforceable if it specifies:

- Employee name and last known address
- Each alternate recipient's name and address
- Coverage the alternate recipient will receive
- The coverage effective date
- How long the child is entitled to coverage
- Each plan subject to the order.

Benefits & Well-Being promptly notifies you and the alternate recipient when a QMCSO is received and explains what procedures will be used to determine if the order is qualified. Once the determination is made, Benefits & Well-Being notifies you and alternate recipient(s) by mail.

✝ Appealing Eligibility

Benefit Eligibility

If you or your family members lose eligibility or are determined ineligible, and you disagree with that decision, you may file a written eligibility appeal to Benefits & Well-Being within 30 days of the event that affected eligibility.

When submitting a benefit eligibility appeal, you must include:

? Your name and address, and each family member's name and address (if applicable)
? Hire letter or job announcement, or retirement determination of eligibility
? Your Employee ID number (as it appears on your paystub) or Social Security number (even if the appeal is for a family member)
? Reason for the appeal.

You'll be notified of the appeal decision in writing within 60 days of receiving your request. If you disagree with the decision, you may request a hearing. All eligibility disputes are subject to binding arbitration under American Arbitration Association rules unless you are covered by a collective bargaining agreement that states otherwise.

Plan Eligibility

If you lose eligibility for one part-time Local 587 benefit plan (Plan 1, 2 or 3), are changed to a different plan and disagree with that decision, you may file a written eligibility appeal to Metro Transit Human Resources within 30 days of receiving notification of the change.

When submitting a plan eligibility appeal, you must include:

? Your name and address
? Plan change notice
? Your Employee ID number (as it appears on your paystub) or Social Security number
? Reason for the appeal.

You'll be notified of the appeal decision in writing within 30 days of receiving your request. If you disagree with the decision, you may file a grievance with Local 587.

✝ Enrolling in the Plans

You receive enrollment materials for each plan as you become eligible.

If you decide to participate in an flexible spending account (FSA), you must submit the FSA enrollment form included in the FSA Guide within 30 days of when your eligibility for Plan 1 or Plan 2 begins (you are not eligible to enroll in an FSA when you change between Plan 2 and 3). Otherwise, you must wait for a qualifying change or the next open enrollment. (You must reenroll each year at open enrollment to continue participating in the FSA Program.)

Plan 1

You must submit your enrollment form within 30 days of your qualifying date. Otherwise, you must wait until the next open enrollment to enroll in Plan 1 and until 2003 open enrollment for 2004 to elect basic life insurance.

Plan 2

You must submit your enrollment form at least 30 before your Plan 2 benefits begin. Otherwise, your eligible family members won't be covered and you'll receive the following default coverage:

? KingCare (Aetna/Ethix) Basic Medical
? Dental
? Vision
? Basic life insurance
? Basic accidental death and dismemberment (AD&D) insurance
? Basic long term disability (LTD) insurance.

If default coverage is assigned, you must wait until the next open enrollment to make changes, and until 2003 open enrollment for 2004 to elect enhanced life insurance.

Plan 3

You must submit your enrollment form at least 30 before your Plan 3 benefits begin. Otherwise, all your previous Plan 2 benefits except basic life, basic AD&D and basic LTD for you will end the day before Plan 3 benefits begin.

Your next opportunity to reenroll for health and enhanced AD&D and LTD will be when you regain eligibility for Plan 2 or the next open enrollment. Your next opportunity to enroll for enhanced life will be 2003 open enrollment for 2004.

✝ When Coverage Begins

You

For most plans, if you're not actively at work the day you would become eligible, coverage begins when you return to work. For Plan 2 LTD, if you're not actively at work because of a physical disease, injury, pregnancy or mental disorder the day before coverage would start, LTD coverage begins when you return to work at least half-time and work at least one day of your normal, scheduled work day.

Plan 1. Coverage begins the first of the month following the day after you qualify.

Plan 2 and 3. Coverage begins the first day of your benefit-eligible period:
? April 1
? August 1
? November 1.

During open enrollment:
? If you move from one part-time Local 587 plan to another, all changes become effective November 1 except changes to your premium payment plan (if applicable). Changes to premium payment plans become effective January 1 of the following year.
? If you remain in the same part-time Local 587 plan, all changes become effective January 1 of the following year.

Family Members

Coverage for your eligible family members does not begin until you submit completed enrollment forms listing them. If you miss the enrollment deadline, you must wait until the next open enrollment or a qualifying change in status to add eligible family members for coverage (pages 9 and 10).

Health Coverage. If enrolled by the deadline, medical, dental and vision coverage for your:
? Newborn or newly placed adopted child is retroactive to the date of birth or placement
? New spouse/domestic partner begins the first of the month following the date of your marriage/establishment of your domestic partnership as indicated on a copy of your marriage certificate or Affidavit of Marriage/Domestic Partnership.

Coverage under all medical plans is provided for newborns under the mother's coverage for the first 3 weeks of life. To continue the newborn's coverage after three weeks, the newborn must be eligible and enrolled within 60 days of the birth.

If your family member is confined in a hospital or other facility at the time coverage would typically begin, coverage will start after discharge (except in the case of newborns or children newly placed for adoption).

Life and AD&D. If you enroll a newborn, newly placed adopted child or new spouse/domestic partner for Plan 2 or 3 life and AD&D, coverage begins the first of the calendar month payroll contributions start. However, if your family member is confined in a hospital or other facility at the time coverage would typically begin, coverage will start after discharge (except in the case of newborns or children newly placed for adoption).

Children younger than 14 days are not eligible for life or AD&D coverage.

✝ Making Changes: General Information

The next three sections describe how to make changes to your benefit coverage between first enrolling and leaving county employment. If a change is due to a qualifying change in status, you must notify Benefits & Well-Being within 60 days following the qualifying event (for example, birth, adoption, death, marriage, establishment of a domestic partnership, divorce, termination of a domestic partnership, etc.) unless otherwise indicated.

Your change may require supporting documentation or related changes. You also may need these additional forms:

- Affidavit of Marriage/Domestic Partnership
- Statement of Termination of Marriage/Domestic Partnership
- Beneficiary Update Form (contact the Washington State Department of Retirement Systems and T. Rowe Price separately if you need state retirement and deferred compensation beneficiary update forms)
- Personal Information Update Form (submit this form to your payroll clerk or personnel representative if your name, address, phone number or emergency contact changes; if the information isn't updated on the payroll system, it cannot be updated by Benefits & Well-Being or your benefit plans).
- Forms included in the FSA Guide.

All guides and forms are available at www.metrokc.gov/ohrm/benefits or from Benefits & Well-Being (see Resource Directory on last two pages).

✝ Changes You May Make Anytime

Drop Family Members From Coverage

Submit a Delete Form to drop family members from coverage. However, if you drop your spouse/domestic partner, he/she must have other coverage and consent to being dropped if the drop is not due to a qualifying change in family status (for example, divorce, termination of the domestic partnership or death). The form must be received by the ninth of the month for the change to take effect the first of the following month.

Drop or Reduce Any Self-Paid Coverage

Submit a detailed written request to Benefits & Well-Being (no form is available). The request must be received by the ninth of the month for the change to take effect the first of the following month. (If you drop or reduce Plan 2 or 3 enhanced life insurance you may not add or increase it again until 2003 open enrollment for 2004.)

✝ Changes You May Make When a Qualifying Change Occurs

Add Family Members for Health Coverage

Submit an Add Form to add a family member for health coverage (medical, dental, and vision) when the change is due to:

? Birth or placement for adoption of a child
? Placement of a foster child
? Marriage or establishment of a domestic partnership
? Qualified Medical Child Support Order
? Significant change in your spouse/domestic partner's employer-sponsored coverage.

Any change you make must be consistent with the qualifying change in status.

Health coverage for your:

? Newborn or newly placed adopted child is retroactive to the date of birth or placement. (Medical coverage is provided for newborns under the mother's coverage for the first three weeks of life. To continue the newborn's coverage after three weeks, the newborn must be eligible and enrolled within 60 days of birth.)
? New spouse/domestic partner begins the first of the month following the date you marry/establish your domestic partnership (as indicated on the copy of your marriage certificate or Affidavit of Marriage/Domestic Partnership).

If your family member is confined to a hospital or other facility at the time coverage would typically begin, health coverage will start after discharge (except in the case of newborns or children newly placed for adoption).

Add Family Members for Life/AD&D Coverage

Submit a Request for Enhanced Family Member Life/AD&D Insurance Form to add a newborn, newly adopted child or new spouse/domestic partner for enhanced life/AD&D. To add the new family member you must have elected enhanced life/AD&D for yourself under Plan 2 or 3 and have not been eligible to elect the family coverage before the qualifying change in status. For example, you may not add a newborn for enhanced life/AD&D if you already had children you could have enrolled in family coverage before the new child was born.

You may not increase coverage for yourself or any currently covered family members when you add the new family member.

If both you and your spouse/domestic partner work for the county and have enhanced life or AD&D for yourselves, and one of you leaves employment, the other (if eligible) may replace the enhanced life/AD&D for family members who would otherwise lose it. For example, if your spouse/domestic partner was the one who enrolled your children for enhanced life and he or she leaves employment, you may enroll your children for enhanced life. You also may enroll your spouse/domestic partner in family coverage under normal plan rules.

Life/AD&D coverage for your family members begins the first of the calendar month payroll contributions start. However, if your family member is confined to a hospital or other facility at the time coverage would typically begin, coverage will start after discharge (except in the case of newborns or children newly placed for adoption).

Children younger than 14 days are not eligible for life or AD&D coverage.

Request Health Coverage Previously Declined

Submit a Request to Opt Back in Medical Coverage Form if you or a family member has health coverage through another employer and loses it. Note on the form if your request is for dental and vision coverage, too.

If your other coverage is COBRA, it must be exhausted before you can opt into coverage outside of open enrollment. For other than COBRA coverage, the loss of coverage must be due to divorce, death, termination of employment, reduction of hours or termination of employer contributions toward the other coverage.

Request Continuation of Coverage for a Disabled Adult Child

Submit a Request to Continue Benefit Coverage for Disabled Adult Child Form for a child currently enrolled in county benefits past age 23 if the child chiefly depends on you for support and maintenance and becomes incapacitated by a developmental or physical disability before turning 23.

✝ Changes You May Make at Open Enrollment

Open enrollment every October lets you make the following changes in coverage without qualifying changes in status:

- Change medical plans
- Add eligible family members not previously covered
- Add or increase enhanced AD&D for yourself and family members (Plan 2 and 3)
- Add enhanced LTD for yourself (Plan 2 and 3)
- Enroll/reenroll in an FSA (you must reenroll each year to continue participating).

If you change from one part-time Local 587 plan to another during open enrollment, election changes you make become effective November 1 except for changes to your premium payment plan. Changes to your premium payment plan become effective January 1 of the next year.

If you remain in the same part-time Local 587 plan during open enrollment, changes you make become effective January 1 of the next year, unless you drop family members or drop or reduce self-paid coverage (changes you may make anytime).

Application for basic life (Plan 1) and enhanced life (Plan 2 and 3) insurance is reserved for special open enrollments. It does not occur annually. If you don't enroll for life insurance when you're first eligible, or drop or reduce your life insurance, you may not add or increase it again (for yourself or family members) until 2003 open enrollment for 2004. Evidence of insurability will be required.

✝ When Coverage Ends

You

Your benefit coverage ends the:

? Last day of the month you lose eligibility, resign, are terminated or retire, or fail to make any required payments for self-paid coverage

? Day the plan terminates or you die (life and AD&D coverage ends when you die, but the benefits you have when you die are paid to your beneficiaries as described in the plan booklets).

AD&D. If you have this coverage it also ends when you have served more than 30 days in the military (except in the Reserve or National Guard duty for training).

LTD. Unless you're approved for and receiving LTD benefits, that coverage also ends when you enter full-time active duty in any armed service.

Family Members

Family member benefit coverage ends the:

? Last day of the month they lose eligibility, your coverage ends or you fail to make any required payments for their coverage

? The day the plan terminates or they die (if they have life and AD&D coverage, it ends when they die, but the benefits they have when they die are paid to you as described in the plan booklets).

Family members may be able to elect continuation coverage under COBRA (page 18).

Life and AD&D. If family members have life or AD&D coverage, it also ends when they have served more than 30 days in the military (except in the Reserve or National Guard duty for training) or when your spouse/domestic partner reaches age 70.

✝ Family-Medical Leave

Eligibility

If you've worked for King County at least a year (need not be 12 consecutive months), and work 510 hours during the 12 months immediately preceding your leave request, you're eligible to take job-protected leave for certain family and medical reasons. Hours counted toward eligibility must be hours actually worked -- vacation and sick leave hours do not count.

Under the Family and Medical Leave Act (FMLA), you're eligible for up to 12 weeks of leave. Under King County Family and Medical Leave (KCFML), you're eligible for up to 18 weeks of leave. However, if you've taken FMLA/KCFML during the 12 months immediately preceding your latest request, your maximum allotment is reduced by that amount.

Reasons for Taking Leave

You may take leave for a these reasons:

? A serious health condition that makes you unable to perform your job
? Caring for your child after birth, adoption or placement for adoption or foster care
? Caring for your spouse with a serious health condition
? Caring for your or your spouse's son, daughter or parent with a serious health condition
? Under KCFML, caring for a domestic partner or domestic partner's son, daughter, or parent with a serious health condition.

A serious health condition is an illness, injury, impairment, or physical or mental condition that involves either inpatient care in a hospital, hospice or residential medical care facility; or continuing treatment by a health care provider.

Advance Notice and Medical Certification

You must submit your leave request 30 days in advance when your leave is foreseeable or as soon as possible when your leave is not foreseeable.

You must provide medical certification to support a leave request because of a serious health condition. If requested, you also must provide second or third opinions (at King County's expense) and a fitness for duty report to return to work.

Use of Sick and Vacation Leave

You must use all your sick leave for your own serious health condition (unless the condition is due to an on-the-job injury). After sick leave is exhausted, you may use vacation and other paid leave if approved.

To care for a family member, you may use sick or, if approved, vacation leave. If you use sick leave, you may reserve up to 80 hours of it for your own future use.

You must use all your own sick or vacation leave before using any donated sick or vacation leave.

When Leave Begins

FMLA leave begins the first day you are off the job. KCFML begins the first day you are no longer being paid from your own sick, vacation or other paid leave accruals. (For an on-the-job injury, you may opt to go on the supplemental payment plan.)

Leave may be taken on a reduced or intermittent work schedule if approved by your supervisor.

Continuation of Benefits

Under FMLA or KCFML, county-paid medical, dental and vision benefits continue while you're on leave. If you go on unpaid leave status, you may pay to continue your life and AD&D up to a maximum of six months (12 months for life effective January 1, 2002) and LTD up to 18 weeks. Benefits & Well-Being contacts you regarding continuation of benefits when it receives a copy of your leave-granting authority's response to your leave request.

Job Protection

Upon return from FMLA leave or KCFML, you are restored to your original or equivalent position with equivalent pay, benefits, seniority and other employment terms. You won't lose any employment benefits that accrued before your leave began. No adverse personnel actions may be taken against you for taking FMLA leave or KCFML, but your job is not protected unless you return to work by the expiration date of your leave. Failure to return by the expiration date may be cause for removal and result in termination of your employment.

King County may not interfere with, restrain or deny the exercise of any right provided under FMLA. The county may not discharge or discriminate against any person for opposing any practice made unlawful by FMLA or for involvement in any proceeding under or relating to FMLA. The U.S. Department of Labor is authorized to investigate and resolve complaints of violations, and an FMLA-eligible employee may bring a civil action against King County for violations.

FMLA does not affect any federal or state law prohibiting discrimination, or supersede any state or local law or collective bargaining agreement that provides greater family or medical leave rights.

✝ Leave of Absence Without Pay

If you do not qualify for leave under FMLA or KCFML, or you continue on leave past your FMLA/KCFML leave period on unpaid status, your benefit coverage:

- Continues uninterrupted if your leave is less than 31 days
- May be continued under COBRA if your leave is 31 days or more (county coverage ends the last day of the month you work before the leave began).

✝ If You Become Disabled

Accommodation Policy

Under federal (American with Disabilities Act), state and local laws, King County provides reasonable accommodations for you if you are disabled, regardless of how or when you become disabled, or whether the disability is permanent or temporary. Disabilities may be caused by injury, accident or disease, or may have been present since birth.

What to Do

If you become disabled:

- ? File a workers' compensation claim with your base chief or supervisor if the disability is work-related
- ? Contact Metro Disabilities Services
- ? Apply for family-medical leave with your supervisor if your disability keeps you from working
- ? File an application for LTD benefits with Benefits & Well-Being if you're in Plan 2 or 3 and are going to be off work for an extended period (you must provide proof of your disability within 12 months after your disability begins and annually thereafter; see your LTD plan booklet)
- ? Contact Associated Administrators Inc., King County's FSA administrator, within 30 days of beginning leave due to the disability if you participate in an FSA and your disability alters expected health care expenses (you may be able to change or discontinue your contributions; see your FSA Guide)
- ? Contact the Washington State Department of Retirement Systems to discuss benefit options if your disability keeps you from working
- ? Contact the Deferred Compensation Plan if you are a participant and your disability has created an unforeseen financial hardship (you may qualify for a hardship withdrawal of funds)
- ? Apply for Social Security disability income if your disability qualifies.

Continuation of Health Benefits

Under Family-Medical Leave. If your disability qualifies you for leave under the Family and Medical Leave Act (FMLA), King County Family and Medical Leave (KCFML) or both, your health (medical, dental, vision) coverage continues. Benefits & Well-Being contacts you regarding continuation of benefits when it receives a copy of your leave-granting authority's response to your leave request.

Under Leave of Absence Without Pay. If you do not qualify for leave under FMLA or KCFML, or you continue on leave past your FMLA/KCFML leave period on unpaid status, your health coverage ends and you may be eligible to pay to continue coverage under COBRA.

If you or covered family members in the KingCare (Aetna/Ethix) Basic or Preferred Medical Plan are totally disabled, and your coverage ends for any reason except plan termination, medical coverage for only the disabling condition may be extended for 12 months (at no cost to you under Plan 2). The disabled person may choose either this medical extension or COBRA coverage, but electing the extension means they forfeit the right to elect COBRA coverage and convert to an individual policy. Other family members may be able to elect coverage through COBRA.

Medical extension coverage will end on the date coverage is terminated for the group you were in when you became disabled or on the date you or your family members experience any of the following:

- ? Reach any lifetime maximum
- ? Are no longer disabled
- ? Become eligible for benefits under another group policy
- ? Reach the end of the 12-month extension.

Continuation of Health Benefits (continued)

If you or covered family members in the PacifiCare or Alliant plan become disabled, coverage under your county medical plan ends. You may be eligible to continue coverage under a family-medical leave and then under COBRA.

Continuation of Life and AD&D

If you have basic life and AD&D coverage under Plan 2 or 3, it continues at no cost to you while you're unable to work due to disability -- up to age 65 for life insurance and up to six months for AD&D insurance. The county will pay your premiums if you meet the LTD disability determination standard. (Submit a copy of your LTD determination letter to Benefits & Well-Being for proof of your disability.)

If you are disabled (as determined by the LTD plan) and still employed by the county, you may self-pay to continue Plan 1basic life or Plan 2 and 3 enhanced life and AD&D up to six months (12 months for Plan 1 basic life and Plan 2 or 3 enhanced life effective January 1, 2002). You must provide proof of your disability and make your premium payments to Benefits & Well-Being. Benefits will be based on your predisability earnings.

Life and AD&D coverage ends when you:

? Are no longer totally disabled
? Fail to provide annual required proof of disability
? Fail to agree to a required health examination
? Reach age 65 for life insurance or reach the end of six months for AD&D insurance.

If your coverage ends and you don't qualify for this disability provision, you may be eligible to convert your life and/or AD&D insurance to an individual policy.

Continuation of LTD

If you have LTD coverage, you may continue it under a family-medical leave for up to 18 weeks by paying the premiums. Once your leave ends, you may continue to pay the premiums through the remainder of your LTD benefit waiting period. While you're receiving LTD benefits, you will not be responsible for monthly premiums.

Job Reassignment and Search Assistance

If you cannot be accommodated in your regular job and are separated from your position, employment placement assistance is provided through the Disability Services Program in two phases, lasting up to nine months. The program will help:

? Place you in a job reassignment through a non-competitive hiring process during the first four months
? You find and apply (with special privileges) to posted job positions for an additional five months if job reassignment is unsuccessful.

✝ COBRA

Eligibility

If you or your qualified family members lose county health coverage due to certain events, each of you has an independent right to self-pay under the Consolidated Omnibus Reconciliation Act (COBRA) for health coverage (medical, dental, vision). This coverage may continue for 18 to 36 months after county coverage ends (the last of the month the qualifying event occurs). Length of the COBRA continuation coverage period depends on the event:

- ? Termination of employment if for reasons other than gross misconduct (18 months)
- ? Lay-off (18 months)
- ? Reduction in work hours/no longer eligible for county-paid Plan 2 benefits (18 months)
- ? Disability (29 months if you or family members are determined Social Security disabled at the time of or within 60 days of when COBRA eligibility begins due to your termination or reduction in hours; the COBRA participant must provide copy of Social Security Disability Determination to Associated Administrators Inc. (AAI), King County's COBRA administrator, before the end of the first 18 months of COBRA and within 60 days after being determined disabled under Social Security)
- ? Death (36 months for surviving qualified family members)
- ? Divorce/dissolution of domestic partnership (36 months for qualified family members)
- ? Dependent child ceases to be a dependent -- no longer claimed as IRS dependent or reaches age 23 (36 months for child)
- ? Medicare entitlement (36 months for qualified family members).

If a second qualifying event occurs during an 18- or 29-month COBRA continuation coverage period, coverage may be continued for up to 36 months from the first qualifying event, but the COBRA continuation coverage period will not exceed 36 months.

You and your qualifying family members may elect coverage even if covered under another employee-sponsored health plan or entitled to Medicare at the time you elect coverage.

Enrollment

COBRA-qualifying events (other than divorce, dissolution of a domestic partnership or child reaching age 23) are reported to Benefits & Well-Being through your termination notice or payroll report. For family members who lose coverage through you because of divorce, dissolution of a domestic partnership or child reaching age 23, you must notify Benefits & Well-Being within 60 days of the last of the month the qualifying event occurs or the date coverage ends, if later. Otherwise, the family member will not be offered the option to elect COBRA continuation coverage.

When COBRA-qualifying information is received, Benefits & Well-Being notifies Associated Administrators Inc. (AAI), who contacts you and/or your family members regarding benefit plan options.

You have 60 days after coverage ends to make your COBRA elections or, if later, 60 days from the date of the AAI letter notifying you of your options. If you elect COBRA continuation coverage, you must make the initial payment by the 45th day after electing it. Thereafter, all premiums are due the first of the month or coverage automatically ends 30 days after the payment due date. AAI will give you payment information.

Because COBRA continuation coverage is retroactive there is no lapse in coverage -- self-paid benefits begin when county benefits end, even if retroactive processing and payments are required. Your initial payment must include all applicable back premiums.

Options

If you elect COBRA, you self-pay to continue the same health coverage you had on your last day of employment or lesser coverage. You may drop coverage or you may drop family members from coverage, as long as the change results in a combination of coverage as described for Plan 1 (page 4).

If you drop family members from coverage, they have their own COBRA rights. However, family members added after you elect COBRA coverage do not have separate COBRA rights, except for newborns and newly adopted children.

Making Changes

If you notify AAI, you may:

? Drop dental and vision and retain medical coverage anytime (notice must be received in the month before you want the change to become effective)
? Drop family members from coverage anytime (notice must be received in the month before you want the change to become effective)
? Add new family members to your health coverage when a qualified change in status occurs (as described for active employees on page 11)
? Change medical plans during open enrollment.

In addition, you may change medical plans between open enrollments if you move out of your current plan's coverage area, provide proof of your new permanent address, enroll in another King County plan that provides coverage in your new location and notify AAI.

When Coverage Ends

COBRA coverage ends the:

? Last day of the month you or your family member fails to make the required payments within 30 days of the due date, becomes entitled to Medicare benefits after electing COBRA, reaches the end of your maximum COBRA coverage period or is no longer disabled as determined by Social Security and has exhausted 18 months of COBRA coverage
? Day the plan terminates, you die or you first become covered under another group health plan after the date of your COBRA election (unless the plan limits or excludes coverage for a preexisting condition of the individual continuing coverage).

The Health Insurance Portability and Accountability Act (HIPPA) restricts the extent group health plans may impose preexisting condition limits:

? If you become covered by another group plan and that plan contains a preexisting condition limit that affects you, your COBRA continuation coverage cannot be terminated. However, if the other plan's preexisting rule doesn't apply to you, your COBRA termination coverage will be terminated.
? You do not have to show you are insurable to choose COBRA continuation coverage. However, COBRA continuation coverage is subject to your eligibility for coverage; King County reserves the right to terminate your coverage retroactively if you are determined ineligible.

You may be entitled to purchase an individual conversion policy when you are no longer covered under the county's plan. An individual conversion policy usually provides different coverage from your group coverage; some benefits you have now may not be available. Also, a conversion policy may cost more than your current coverage.

✝ Retiree Benefits

Eligibility

If you retire, county coverage ends the last of the month you retire. You may self-pay to continue medical and vision coverage (but not dental coverage) if you:

- ? Have county benefits on your last day of employment
- ? Have worked for King County for at least five consecutive years before you retire
- ? Are not eligible for Medicare
- ? Are not covered under another medical group plan
- ? Meet the requirements for formal service or disability retirement under the Washington State Public Employees Retirement Act or the City of Seattle Retirement Plan (which applies only if you elected to remain under the City of Seattle system according to a formal agreement between King County and the City of Seattle).

Covered family members are eligible for continued coverage under your retiree benefits if they're not eligible for Medicare and meet the same eligibility requirements in effect when you were an active employee. Life, AD&D and LTD coverage (in addition to dental coverage) is not available under retiree benefits.

Enrollment

Your retirement is reported to Benefits & Well-Being through your termination notice or payroll report. Benefits & Well-Being then notifies Associated Administrators Inc. (AAI), who contacts you regarding benefit plan options.

You have 60 days after county coverage ends to make retiree elections or, if later, 60 days from the date of the AAI letter notifying you of your options. If you elect retiree benefits, you must make the initial premium payment by the 45th day after electing it. Thereafter, all premiums are due the first of the month, or coverage automatically ends 30 days after the payment due date. AAI will give you payment information.

Because retiree benefit coverage is retroactive there is no lapse in coverage -- self-paid benefits begin when county benefits end, even if retroactive processing and payments are required. Your initial payment must include all applicable back premiums.

Options

If you elect retiree benefits, you self-pay to continue the same health coverage you had on your last day of employment. Your options for retiree coverage include:

- ? Medical and vision
- ? Medical only.

You may continue covering the same family members who were covered the last day of your employment or you may drop any of them from coverage at any time. If you drop family members from coverage, they have COBRA rights.

Making Changes

If you notify AAI, you may:

? Drop vision and retain medical coverage anytime (notice must be received in the month before you want the change to become effective)
? Drop family members from coverage anytime (notice must be received in the month before you want the change to become effective)
? Add new family members to your health coverage when a qualified change in status occurs (as described for active employees on page 11)
? Change medical plans during open enrollment.

When Coverage Ends

Retiree benefits end the:

? Last day of the month you fail to make the required payments within 30 days of the due date or become entitled to Medicare benefits after electing retiree benefits
? Day the plan terminates, you die or you first become covered under another group health plan after the date of your retiree benefit election (unless the plan limits or excludes coverage for a preexisting condition of the individual continuing coverage).

HIPPA restricts the extent group health plans may impose preexisting condition limits:

? If you become covered by another group plan and that plan contains a preexisting condition limit that affects you, your retiree coverage cannot be terminated. However, if the other plan's preexisting rule doesn't apply to you, your retiree coverage will be terminated.
? You do not have to show you are insurable to choose retiree coverage. However, retiree benefits are subject to your eligibility for coverage; King County reserves the right to terminate your coverage retroactively if you are determined ineligible.

✝ If You Leave Employment to Perform Uniformed Service

You need to provide Benefits & Well-Being with written notice both when you leave employment to perform uniformed service (such as the military) and when you return to employment after uniformed service. While performing uniformed service your benefit coverage may be continued, depending on the circumstances.

If you leave employment to serve in the military on demand of the United States Government, you may be eligible for benefits under the Uniformed Services Employment and Reemployment Rights Act of 1994 (USERRA) and King County Ordinance 13377. Call Benefits & Well-Being for more information.

Continuation of Health Benefits

You may continue your health (medical, dental, vision) coverage up to the shorter of 18 months or the period of your service. Generally, you must pay for the full cost of coverage. To be eligible, you must meet the requirements under USERRA. The Veterans' Employment and Training Administration also is required to assist you. If you don't arrange to continue medical, dental and vision coverage, it will end the last day of the month you leave employment.

Continuation of Life, AD&D and LTD

If you have the benefits, you may continue your basic life and AD&D coverage up to six months by paying the premiums; you may continue your LTD coverage up to 30 days by paying the premiums. If you do not make arrangements to continue these benefits, coverage will end the day you leave employment.

✝ If You're on a Mutual Aid Assignment

Occasionally, for instance in the case of a natural disaster, you may be asked to work temporarily for another agency in need of extra help. If you need health care while you're working in this situation, you will not pay more for the care because you're outside your usual area.

Submit claims directly to the Manager of Benefits & Well-Being for processing and payment.

If you are on loan to a Borrower under the Northwest Mutual Aid Group Omnibus Agreement, you will continue to be covered under your regular medical, dental and vision plan. If, as a result of this arrangement, you receive services outside of the normal network area covered by your plan, your care will be covered by the county at the network level.

✝ If You Enter Into a Labor Dispute

If you enter into a labor dispute, your King County coverage ends. If your pay is suspended directly or indirectly as a result of a strike, lockout or other labor dispute, you may be able to continue your medical, dental and vision coverage temporarily by paying the full cost:

- Medical, dental and vision coverage for up to 18 months (you may also continue participating in a Health Care FSA by contributing on an after-tax basis; see your FSA Guide)
- Life and AD&D coverage for up to six months (check with the insurance companies if you want to convert your life and AD&D coverage to individual policies).

✝ If Someone Dies

You

If you die while a participant in King County benefit plans, your family must provide a death certificate to Benefits & Well-Being. When that occurs, Benefits & Well-Being will assist your family with:

- Completing a claim for any life insurance benefit they're entitled to receive (if death due to accident, accident report required)
- Understanding COBRA and options for continuing the health coverage they had through you
- Submitting claims for reimbursement under an FSA if you were enrolled (see FSA Guide)
- Counseling and referral through the Making Life Easier Program.

LTD. If you die while on LTD, a lump sum benefit is paid to your eligible survivors. The survivor benefit is three times your last gross monthly benefit. The survivor benefit will first be applied to reduce any overpayment of your claim. A survivor benefit would be payable to any one or more of the following:

- Your spouse or a domestic partner for whom you have filed a copy of your marriage certificate or Affidavit of Marriage/Domestic Partnership
- Your unmarried children under age 25
- Any person providing care and support for any of your eligible survivors.

If there is no eligible survivor, no payment will be made.

Family Member

If your family member dies while you are a participant in King County benefit plans, contact Benefits & Well-Being for assistance with:

- Completing a claim for any life insurance benefit you're entitled to receive (death certificate required; if death due to accident, accident report also required)
- Completing other benefit paperwork as required (Delete, Beneficiary Update Forms, etc.)
- Reevaluating your need for participation in an FSA if it is affected by your family member's death (see FSA Guide)
- Counseling and referral through the Making Life Easier Program.

✝ Assignment of Benefits

Plan benefits are available to you and your covered family members only. The right to payment under these plans is not subject to attachment or garnishment, and the plans will not honor any assignment of benefits to anyone.

In paying for services, the plans may, at their option, make the payment to you, the provider or another carrier. The plans also will make payments on behalf of an enrolled child to his or her non-enrolled parent or a state Medicaid agency when required to do so by federal or state law. In these cases, the plans also have the right to make joint payments.

All payments are subject to applicable federal and state laws and regulations. Payments made according to this section will discharge the plans to the extent of the amount paid, so that the plans will not be liable to anyone aggrieved by their choice of payee.

LTD. Your rights and benefits under LTD are not assignable. In other words, you may not transfer your rights and benefits to another party.

✝ Third Party Claims

If you receive benefits for any condition or injury for which a third party is liable, the plans may have the right to recover the money they paid for benefits. This means the plans are not obligated to pay for services necessary because of an injury or condition for which you may have other recovery rights unless or until you (or someone legally qualified and authorized to act for you) promise in writing to:

? Include those amounts in any claim you or your representative makes for the injury or condition
? Repay the plan those amounts to the extent the proceeds of your recovery for the injury or condition exceed the total loss, prorating any attorneys' fees incurred
? Cooperate fully with the plans in asserting their rights by supplying all information and executing all documents reasonably needed for that purpose.

Any sums collected by or for you or your covered family members by legal action, settlement or otherwise on account of these benefits are payable to the plans only after and to the extent they exceed the amount required to fully compensate your loss. This provision does not apply to LTD.

✝ Recovery of Overpayments

The plans have the right to recover amounts they paid that exceed the amount for which they are liable. These amounts may be recovered from one or more of the following (to be determined by the plans):

? Persons to or for whom the payments were made
? Other insurers
? Service plans
? Organizations or other plans.

These amounts may be deducted from your future benefits (or your family members' benefits, even if the original payment was not made on that family member's behalf).

The plans' right of recovery includes benefits paid in error due to any false or misleading statements made by you or your family members.

✝ Termination and Amendment of the Plans

The county fully intends to continue plan benefits indefinitely, but also reserves the absolute right to amend or terminate the plans for any reason at any time. If the county amends or terminates the plans, bona fide claims incurred before the amendment or termination will be paid.

LTD. Your right to receive LTD benefits for a period of disability that begins while you're covered will not be affected by plan amendment or termination, or termination of your coverage.

✝ Medical Plan Bill of Rights

Dignity and Respect

You have the right to:

? Be treated with consideration, dignity and respect. You also have the responsibility to respect the rights, property and environment of all providers and other patients.

? See your own medical records and to have those records kept private and confidential unless required to settle a claim.

You have these rights regardless of your gender, race, sexual orientation, marital status, culture or economic, educational or religious background.

Knowledge and Information

You have the right -- and the responsibility -- to know about and understand your health care and your coverage, including:

? Names and titles of all providers involved in your medical care

? Medical condition and health status

? Services and procedures involved in your treatment plan

? Ongoing health care you need once you're discharged or leave the physician's office

? How the plans work (you will find that information in your plan booklet)

? Medication prescribed for you -- what it is, what it's for, how to take it properly and possible side effects.

You also have the right to take an active part in decisions about your medical care. Once you participate in and agree to a treatment plan, you are responsible for following that plan or telling your physician otherwise.

Continuous Improvement

You have the right to:

? Call or write with any questions or concerns and make suggestions for improving the plans

? Ask your physician to explain or give you more information about any medical advice or prescribed treatment

? Appeal any medical or administrative decisions (see "Appealing a Claim" in your medical plan booklet).

Plan Participant Accountability and Autonomy

As a partner in your own health care, you have the right to:

? Refuse treatment -- as long as you accept responsibility and the consequences of that decision
? Complete an advance directive, such as a living will or durable power of attorney, for health care
? Refuse to take part in any medical research projects
? Be advised on the full range of treatment options (whether covered under the plans or not) and their potential risks, benefits and costs
? Make the final choice among treatment alternatives.

You also are responsible to:

? Show your ID card to your physician, hospital or other provider before you receive care
? Give your current provider all previous medical records and submit accurate, complete medical information to all physicians or other providers involved in your care
? Be on time for appointments and let your physician's office know as far in advance as you can if you need to cancel or reschedule
? Follow instructions given by those providing your care
? Send copies of claim statements or other documents if requested
? Let the plan and your primary care provider (if applicable) know within 24 hours, or as soon as reasonably possible, if you receive emergency care or out-of-area urgent care
? Tell the plan and your primary care provider (if applicable) about planned health care, such as a surgery or an inpatient stay
? Pay all required copayments when you receive health care.

If you decide to give someone else the legal power to make decisions about your health care, that person also will have all of these rights and responsibilities.

✝ Glossary of Terms

AD&D. Accidental death and dismemberment.

Beneficiary. The person or organization you designate to receive any life or AD&D insurance benefits payable at the time of your death.

COBRA. Consolidated Omnibus Budget Reconciliation Act. Implemented in 1986, COBRA allows you to continue your health coverage on a self-paid basis under certain circumstances for a limited time. King County offers no greater COBRA rights than required, except spouse rights are extended to domestic partners.

Disability - Medical. A condition determined to be disabling by the Social Security Administration, Public Employees Retirement System (PERS) or the county-sponsored Long Term Disability Plan.

Disability - Life and AD&D. LTD disability determines disability for life and AD&D.

Disability - LTD. Until LTD benefits have been paid for 24 months, you are disabled if you're unable to perform (with reasonable continuity) the material duties of your own occupation. Thereafter, you will continue to be considered disabled if you are unable to perform (with reasonable continuity) the material duties of any gainful occupation for which you are reasonably qualified by education, training and experience.

FMLA. Family and Medical Leave Act. Implemented in 1993, FMLA allows you to take up to 12 weeks of unpaid, job-protected leave for certain family and medical reasons if you meet eligibility requirements.

Gross Monthly Benefit. Your monthly LTD benefit before any reduction of other income benefits.

HIPAA. Health Insurance Portability and Accountability Act. Effective in 1996, HIPAA restricts the extent to which group health plans may impose preexisting condition limitations.

KCFML. King County Family and Medical Leave. Passed by King County Ordinance 13377 in 1998 and adopted by most but not all labor unions representing King County employees. Allows you to take up to 18 weeks of unpaid, job-protected leave for certain family and medical reasons if you meet eligibility requirements.

LTD. Long term disability.

Mutual Aid Agreement. If you are needed to work temporarily for another agency, this agreement allows certain benefits to continue while you're away from the county.

Open Enrollment. The annual period when benefit-eligible employees may join a plan, change plans and add or drop family members' coverage. Some enrollment restrictions apply to life insurance.

Premium Payment Plan. The payroll deduction plan you elect to pay for self-paid health benefits under Plan 1 and 3. You may pay benefit premiums before-tax or after-tax. The option you choose remains in effect for the calendar year and may only be changed at open enrollment.

QMCSO. Qualified Medical Child Support Order. A decree, judgment or order from a state court (including approval of a settlement agreement) or administrative order that requires benefit plans to include a child in your coverage and make any applicable payroll deductions.

USERRA. The Uniformed Services Employment and Reemployment Rights Act of 1994.

✝ Resource Directory

Questions About ...	Contact ...
Eligibility for Plan 1, 2 or 3	**Your Base Chief**
General Benefits ? Health and life insurance plans ? Enrollment guides ? PERS enrollment ? Flexible Spending Account enrollment ? Plan booklets ? Change forms ? Alternate formats	**Benefits & Well-Being** Yesler Building YES-HR-0500 400 Yesler Way, Seattle WA 98104-2683 Phone 206-684-1556* ✍1-800-325-6165 x41556* Fax 206-684-1925 E-mail kc.benefits@metrokc.gov Web www.metrokc.gov/ohrm/benefits
Medical ? Providers (doctors, hospitals, pharmacies, mail order prescriptions, etc.) ? Filing claims ? Other plan details (covered expenses, limitations, exclusions, preauthorization)	**KingCare/Aetna** PO Box 91023, Seattle WA 98111-9123 Phone 1-800-654-3250* x77020 ✍206-701-1100* E-mail kingcare@aetna.com Web www.kingcare.com **Express Scripts** mail order Rx for KingCare PO Box 52123, Phoenix AZ 85027-2123 Phone 1-888-201-5853* ✍1-800-296-2956* (refills) E-mail thru Web www.express-scripts.com **PacifiCare** PO Box 3005, Hillsboro OR 97123 Phone 1-800-932-3004* E-mail thru Web www.pacificare.com **Prescription Solutions** mail order Rx for PacifiCare PO Box 9040, Carlsbad CA 92018-9040 Phone 1-800-562-6223* E-mail thru Web www.pacificare.com **Virginia Mason/Group Health Alliant** PO Box 1207, Seattle WA 98111-1207 Phone 1-800-442-4038* E-mail info@ghc.org Web http://www.ghc.org/web/health_plans/alliantselect/index.jhtml
Dental ? Providers ? Filing claims ? Other plan details	**Washington Dental Service** PO Box 75688, Seattle WA 98125-0688 Phone 1-800-554-1907* ✍206-522-2300* E-mail cservice@deltadentalwa.com Web www.deltadentalwa.com
Vision ? Providers ? Filing claims ? Other plan details	**Vision Service Plan** PO Box 997100, Sacramento CA 95899-7100 Phone 1-800-877-7195* E-mail thru Web www.vsp.com

* TTY 1-800-833-6388 (Washington Relay Service)

Questions About ...	Contact ...
COBRA & Retiree Benefits	**Associated Administrators Inc.** PO Box 3988, Portland OR 97208-3988 Phone 1-800-320-2915* ✍Fax 503-727-7444 E-mail cobra@aai-tpa.com
Counseling & Resource Referral ? Personal, family and work problems ? Financial and legal matters ? Child care, elder/adult care	**Making Life Easier** Phone 1-888-874-7290* (24 hours a day, seven days a week)
Deferred Compensation ? Enrollment ? Changes (beneficiaries, contributions, allocations, etc.) ? Quarterly work site seminars	**T. Rowe Price** PO Box 17215, Baltimore MD 21297-1215 Phone 1-888-457-5770* E-mail thru Web rps.troweprice.com/kingcounty/retirementplan/
Disability Services ? Essential job function assessment ? Job modification	**Metro Disability Services** Phone 206-684-1204.
Flexible Spending Account Processing ? Account balances ? Changing contributions ? Reimbursement	**Associated Administrators Inc.** PO Box 3199, Portland OR 97208-3988 Phone 1-800-334-4340* ✍Fax 1-800-979-8987 E-mail flex@aai-tpa.com
Washington State Retirement System ? General information ? Beneficiary designation ? Beneficiary and address changes ? Disability benefit options	**Washington State Department of Retirement Systems** PO Box 48380, Olympia 98504-8380 Phone 1-800-547-6657 ✍360-664-4700 ✍360-586-5450 (TTY) E-mail recep@drs.wa.gov Web www.wa.gov/drs/drs.html
Workers' Compensation ? On-the-job illness or injury ? Benefits ? Claims	**Safety & Claims Management** Boeing Field AIR-HR-0103 PO Box 80283, Seattle WA 98108 Phone 206-296-0510* ✍1-800-325-6165 x60510* Fax 206-296-0514 Intranet ohrm.metrokc.gov/safety/claiminfo/comphome.htm

* TTY 1-800-833-6388 (Washington Relay Service)